STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155747	B. WIN			08/24/	2012
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1300 M	IERCER AVE		
WOODCI	REST NURSING C	ENTER		DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0000							
	This visit was f	or a Recertification and	F00	00			
			1 100	00			
	State Licensure	e Survey.					
	Survey dates:	August 20, 21, 22, 23					
		August 20, 21, 22, 23					
	and 24, 2012						
	Facility number	r: 000556					
	Provider numb						
	AIM number: 1						
	Alivi Hullibel.	1002900130					
	Survey Team:						
	Linn Mackey, F	DNI TC					
	Shelley Reed,						
	•						
	Karen Lewis, R						
	Ginger McNam	iee, Riv					
	Census bed typ	20.					
	SNF/NF: 126	ye.					
	Total: 126						
	10tai. 120						
	Census payor	tvne.					
	Medicare: 14	iypo.					
	Medicaid: 75						
	Other: 37						
	Total: 126						
	10tai. 120						
	These deficion	cies reflect state					
		n accordance with 410					
	IAC 16.2.	i accordance with 410					
	IAC 10.2.						
	Quality ravious	8/30/12 by Suzanno					
	-	8/30/12 by Suzanne					
	Williams, RN				I		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUILD		NSTRUCTION 00	(X3) DATE S COMPL 08/24 /	ETED	
		133747	B. WING	CED DET.	DDDEGG CUTY CTATE TID CODE	00/24/	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING CI	ENTER			UR, IN 46733		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0157 SS=D	resident; consult of physician; and if I legal representation member when the the resident which the potential for reintervention; a significantly (i.e., a deteor psychosocial status (i.e., a significantly (i.e., existing form of treonsequences, or of treatment); or a discharge the resspecified in §483.	ME/ROOM, ETC) mediately inform the with the resident's known, notify the resident's eve or an interested family ere is an accident involving in results in injury and has equiring physician unificant change in the al, mental, or psychosocial erioration in health, mental, tatus in either life tions or clinical need to alter treatment a need to discontinue an eatment due to adverse or to commence a new form a decision to transfer or ident from the facility as 12(a).					
	resident and, if kr representative or when there is a cl roommate assign §483.15(e)(2); or under Federal or specified in paragonal that it is addressed to the resident's legal interested family a Based on reconsinterview, the fathe physician was for having brown	ment as specified in a change in resident rights State law or regulations as graph (b)(1) of this section. record and periodically ss and phone number of all representative or member.	F0157	7	It is the policy of this provider timmediately inform the resider consult with the resident's physician, and notify the resident's legal representative a significant change in the	nt,	09/15/2012

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Event ID: 5ZUI11

Facility ID: 000556

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DI III	DDIC	00	COMPL	ETED
		155747	A. BUII			08/24/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
WOODO		ENTED			ERCER AVE		
WOODC	REST NURSING C	ENIER		DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	medications. [F	Resident #18]			resident's condition. The prov		
	-	<u>-</u>			respectfully request IDR of this	3	
	Findings include:				alleged deficiency. <u>1. What</u>		
					corrective action will be		
	D = =: d = ==	aliainal anna anda			accomplished for those reside		
		s clinical record was			found to have been affected by		
		23/12 at 8:52 a.m. The			the deficient practice: Residen		
	_	noses included, but			#18 did not return to the facility no action is required for this	,	
	were not limite	d to, status post small			resident. 2. How other resider	nts	
	bowel obstruct	ion of the ileus, atrial			having the potential to be affect		
	fibrillation, hyp	ertension, congestive			by the same alleged deficient		
		nd chronic back pain.			practice will be identified and		
	l loant landro, a	na ememe baek pann			what corrective action will be		
	Dovious of Doo	ident #10's pursing			taken: Other residents with the	;	
		ident #18's nursing			propensity to be affected by th	е	
	notes indicated	•			alleged deficient practice were		
	•	m., The resident was			identified as those with nausea	a	
	vomiting a mod	derate amount of brown			and vomiting. None were so		
	liquid and her	6:00 p.m. medications			identified. <u>3. What measures</u>		
	were held. The	e resident was given 30			be put into place or what syste		
	cc of Al-Mag [a	an antacid]. Her vital			changes will be made to ensure that the alleged deficient pract		
		ained at the time.			does not recur: The process of		
	0.9.10 110.0 0.0	amou at the time.			reading all nurses' notes on a	•	
	0/6/10 0:00 5	m The recident			daily basis (in place for > one		
	•	m., The resident			year) by the Unit Managers wil	I	
		lerate amount of brown			continue unchanged. The unit		
		8:00 p.m. medications			managers will during that revie	eW,	
	were held.				will monitor any residents		
					identified with nausea and		
	8/6/12, 11:00 p	o.m., "Dr. called. Res			vomiting or possible bowel		
	[resident] aller	gic to Phenergan [for			obstruction. The weekly Resid Care Committee will review 3	ent	
		omiting]. [Circle with a			charts randomly selected to		
	line through it]	<u>-</u>			assess if a patient has nausea		
		ng] med [medication]			and vomiting or a possible boy		
	_				obstruction and if affirmed, that		
	available. Order received to send res			physician notification has			
		spital] ER [emergency			occurred within a professional		
	room.] Daugh	ter notified."			standard parameter. If it has n		
					corrective in-servicing will occu	ır.	

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Event ID: 5ZUI11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	I DINC	00	COMPL	ETED
		155747		LDING		08/24/	2012
			B. WIN		DDDEGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ENTER			ERCER AVE		
WOODCI	REST NURSING C	ENTER		DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	8/7/12, 3:30 a.	m., Received a call			A summary of these findings w	/ill	
	from the emer	gency room and the			be forwarded to the DNS or		
		eing admitted with a			designee to present to PI/QA&		
		l obstruction and			Committee for review, monthly		
	hypokalemia.	. ozou douom and			3 months and quarterly therea 4. How the corrective action was		
	i ilypokaleiilia.				be monitored to ensure the	<u>////</u>	
	0/7/40 1-1-	tm . fan 0/0/40 - 44:00			deficient practice will not recur	i.e.	
	•	try for 8/6/12, 11:00			what quality assurance progra		
		dent had vomited a			will be put into place: The		
	large amount o	of brown liquid.			PI/QA&A Committee will review	W	
					the summary from above and		
	During an inter	view with the Director			make recommendations based		
	of Nursing on 8	8/23/12 at 3:30 p.m.,			on the summaries for continue		
	_	he physician was not			monitoring. <u>5. Completion dat</u>	<u>e:</u>	
		6/12 at 11:00 p.m. The			September 15, 2012.		
		sician Notification" was					
	•	n the Director of					
	Nursing during	the interview.					
	No further info	rmation was provided					
	related to the "	Physician Notification"					
	policy as of the	e time of exit 8/24/12 at					
	12:10 p.m.						
	- F						
	3.1-5(a)(2)						
	σ. ι σ(α <i>)</i> (<i>Σ)</i>						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:		nn.c	00	COMPL	ETED
		155747		LDING		08/24/	2012
		1007.17	B. WIN			00/2 !/	2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
THE OF T	NO VIDER OR SOLVER			1300 M	ERCER AVE		
WOODCF	REST NURSING C	ENTER		DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
F0159	483.10(c)(2)-(5)						
SS=B		GEMENT OF PERSONAL					
33-Б	FUNDS	OLIVILITY OF TEROONAL					
		norization of a resident, the					
	•	safeguard, manage, and					
	•						
	•	ersonal funds of the					
	•	d with the facility, as					
		graphs (c)(3)-(8) of this					
	section.						
	The facility must o	deposit any resident's					
		excess of \$50 in an					
	•	ccount (or accounts) that is					
	•	,					
		y of the facility's operating					
		at credits all interest earned					
		ds to that account. (In					
	•	there must be a separate					
	accounting for ea	ch resident's share.)					
	The facility must r	maintain a resident's					
	•	at do not exceed \$50 in a					
	non-interest beari						
		account, or petty cash fund.					
	interest bearing a	occount, or porty cash fana.					
		establish and maintain a					
	system that assur	res a full and complete and					
	separate account	ing, according to generally					
	accepted account	ting principles, of each					
		al funds entrusted to the					
	facility on the resi						
	·						
		preclude any commingling					
	of resident funds	with facility funds or with					
		person other than another					
	resident.						
	The individual fina	ancial record must be					
	available through	quarterly statements and					
		resident or his or her legal					
	representative.						
	•						
	The facility must r	notify each resident that					

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Event ID: 5ZUI11

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155747	B. WIN			08/24/	2012
NAME OF B	AN OLUMBER OR GURBLUE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	· ·		1300 M	IERCER AVE		
	REST NURSING C	ENTER			UR, IN 46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		d benefits when the amount account reaches \$200 less					
		ource limit for one person,					
		on 1611(a)(3)(B) of the Act;					
	and that, if the amount in the account, in						
		alue of the resident's other					
	· ·	urces, reaches the SSI					
		one person, the resident ty for Medicaid or SSI.					
		view, the facility failed	F01	59	It is the policy of this provider	to	09/15/2012
		lents had ready access		~ /	ensure residents have ready		07/10/2012
		al account funds			access to their personal accou	unt	
	•	ne facility for 2 of 5			funds managed by the facility.		
		viewed of the 5					
		met the criteria for			The provider respectfully required IDR of the alleged deficiency.	ests	
					IDR of the alleged deliciency.		
	•	of personal account			1. What corrective action will b	oe .	
	-	entially affecting all			accomplished for those reside		
		have personal fund			found to have been affected b	<u>y</u> _	
		the facility. (Resident			the deficient practice:		
	#57 and #50)				Resident #57 and Resident #5	sn	
	e				were informed of the procedur	-	
	Findings includ	ie:			obtain funds from their person		
	4 . 5 .				accounts on the weekends an	d	
		esident interview on			after hours.		
		6 p.m., Resident #57			2. How other residents having	,	
		ent personal funds			the potential to be affected by		
	were not acces	ssible on the			same alleged deficient practice		
	weekends.				will be identified and what		
					corrective action will be taken:	<u>.</u>	
	, ,	esident interview on			Other project of 10 th		
		9 p.m., Resident #50			Other residents with the propensity to be affected by the	10	
		ent personal funds			alleged deficient practice were		
	were not acces	ssible on the			identified as those with facility		
	weekends.				managed personal fund		
					accounts. 52 were so identifie	ed.	
	3.) During an	interview with the			0 14/1-4		
					3. What measures will be put	<u>ınto</u>	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED
		155747	B. WING	i		08/24/2012
NAME OF P	PROVIDER OR SUPPLIER		· I	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-
					ERCER AVE	
WOODCI	REST NURSING CI	ENTER		DECAT	UR, IN 46733	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		e Manager on 8/22/12			place or what systemic change	
		she indicated the			will be made to ensure that the alleged deficient practice does	
		nave banking hours on			not recur:	<u>-</u>
	the weekends.					
					All residents and family memb	
	3.1-6(f)(1)				of residents, who have a facilit	
					managed personal account, w reminded of the procedure to	ere
					obtain funds from the business	s
					office during the weekends an	
					after hours, while the survey w	vas 💮
					in progress. All admissions are	
					notified of this policy upon enti	ry
					into the facility.	
					4. How the corrective action v	vill
					be monitored to ensure the	
					deficient practice will not recui	
					what quality assurance progra	<u>m</u>
					will be put into place:	
					Through the Guardian Angel	
					Program, all residents will be	
					queried as to the proper	
					procedure to obtain funds from	
					their personal accounts manage	
					by the facility on weekends an after hours. The guestion will t	
					asked during the Guardian An	
					Resident interview. Queuing w	-
					be provided to assist in	
					recollection/retention. The res	ults
					of the interviews for those	
					residents with FMPA's will be reported to the Business Office	
					manager who will report to the	
					QA&A/PI committee monthly	
					6 months. It will review and	
					recommend further action as i	t
					sees fit.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CO A. BUILDING B. WING	COM	COMPLETED 08/24/2012				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733					
WOODCI (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) 5. Completion date: 2012.	PPROPRIATE	(X5) COMPLETION DATE		

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Event ID: 5ZUI11

Facility ID: 000556

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155747	B. WIN	G		08/24/	2012
	ROVIDER OR SUPPLIER			1300 M	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE TUR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0241 SS=D	in a manner and imaintains or enhadignity and respect or her individuality. Based on interversive, the facistaff treated research dignity for reviewed for residents who dignity. (Resident indicates with respect and resident indicates take her to the leave her therefore. She indicates the formula occasionally good on the come bacall light on and for a long time. Tight leg often the her hip and her from sitting too	promote care for residents in an environment that ances each resident's ct in full recognition of his y. view and record ality failed to ensure the sidents with respect 1 of 2 residents spect and dignity of 2 met the criteria for ent #139) The resident and the resident and the for long periods of the cated that she test nervous when they ack and she will put her at they do not answer and supply is cut off long. Resident #139 identify the staff will safe and sidentify the staff in an environment with the staff and supply is cut off long. Resident #139 identify the staff	F02	41	It is the policy of this provider to provide care for residents in a manner that enhances resident dignity and respect in full recognition of his/her individuality The provider respectfully requests IDR for the alleged deficiency. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident #139 was interviewed by facility staff uponotification of this concern. Stawas instructed to give "cares in pairs," and to document the length of time that the resident afforded privacy for elimination. The facility was unaware (as documented by the survey findings) of any concern regarding resident dignity. The resident was reminded to alert staff (Unit manager and Guard Angel) if this continues to or active to make the future. How will other resident having the potential to be affected by the same deficient practice be identified and who corrective actions will be taken? All residents who have maximum assistance required	nis nis nis nis nis ne ne ne ne ne ne ne ne ne n	09/15/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155747	A. BUIL B. WING			08/24/2012	
		ı	J. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ERCER AVE		
WOODC	REST NURSING C	ENTER			UR, IN 46733		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	PLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	·		OATE
					assistance in toileting have the potential to be affected and wi		
	The resident ir	ndicated the incident			be identified during Guardian	"	
	was not report	ed.			Angel rounds weekly. The		
					question "Is your call light		
	Resident #139	's clinical record was			answered timely?" will be aske	ed	
	reviewed on 8/	/22/12 at 3:17 P.M.			and negative responses		
					addressed by the Guardian		
	Resident #130	's diagnoses included,			Angel, on the spot. What		
		mited to: anxiety,			measures will be put into pla		
		•			or what systemic changes w	<u> </u>	
	hypertension,				be made to ensure that the		
	1	n, congestive heart			deficient practice does not recur? House-wide staff		
	failure and righ	•			members have received training	na l	
	Resident #139	scored a 15 of 15 for			related to dignity. How will the	_	
	the brief interv	iew mental status			corrective actions be	-	
	(BIMS) on the	Minimum Data Set			monitored to ensure the		
	assessment (N	/IDS) dated 7/23/12			deficient practice does not		
	,	resident was reliably			recur? Information gathered for	om	
	interviewable.				the bi-weekly Guardian Angel		
	intorviowabio.				round audit tools will be		
	During the con	no record review the			summarized and the findings	VIII	
	_	ne record review, the			be forwarded to the DNS or designee to present to PI/QA8	^	
		eting record was			Committee for review, monthly		
		indicated the resident is			3 months and quarterly therea		
	1	two hours. The MDS			Recommendations from the		
	dated 7/23/12	indicated the resident			PI/QA&A committee for chang	es	
	required one p	erson staff assistance			to monitoring schedule will be		
	to move to and	from the toilet. She			forwarded back to the Director		
	was continent	of bowel and			Nursing for implementation B	<u>′</u>	
	incontinent of I	bladder. The resident			what date will the systemic		
		nt on both upper and			changes be completed?		
	-	es and required the			September 15, 2012.		
		•					
	assistance of a	a walker for mobility.					
	Distribute at a second second	ndawwille Castal					
	_	rview with Social					
		ant #1 on 8/24/12 at					
	9:19 a.m., she	indicated she was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155747	B. WIN			08/24/	2012
NAME OF I	PROVIDER OR SUPPLIEF	3	•		ADDRESS, CITY, STATE, ZIP CODE		
WOODC	REST NURSING C	ENTER			ERCER AVE UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	concerns relate toilet too long a the resident re concerns, as w						
	dated 2/9/00 till which was proving on 8/2 indicated the formula "Dignity. The force for reside an environment enhances each	trrent facility policy tled "Resident Rights" vided by the Director of 0/12 at 10:00 a.m., collowing: facility must promote ints in a manner and in int that maintains or in resident's dignity and recognition of his or her					

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Event ID: 5ZUI11

Facility ID: 000556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155747	B. WIN			08/24/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
MOODO		ENTED			ERCER AVE		
WOODCI	REST NURSING CI	ENTER		DECAT	TUR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282	483.20(k)(3)(ii)						
SS=D	SERVICES BY Q	UALIFIED PERSONS/PER					
	CARE PLAN						
	The services prov	vided or arranged by the					
	facility must be pr	ovided by qualified					
	persons in accord	dance with each resident's					
	written plan of car	re.					
	Based on recor	rd review and	F02	82	It is the policy of this provider t	:0	09/15/2012
	interview, the fa	acility failed to ensure			ensure that the services provide		
	-	ff monitored and			by or arranged by the provider		
	_	resident's fluid intake			rendered by qualified personne	el	
					and in accordance with the		
	•	tula in accordance with			resident's written care plan.		
	•	e for 1 of 1 resident			What corrective actions will	<u>be</u>	
	reviewed for di	alysis. (Resident #5)			accomplished for those		
					residents found to have been	<u>1</u>	
	Findings includ	e:			affected by the deficient		
	3 - 3 - 3				practice? Resident #5 will have		
	1) The clinical	I record for Resident			the fistula assessed each shift and the fluid restriction of 1500	•	
	•				maintained by record of intake		
		ed on 8/23/12 at 8:20			How will other residents	•	
	a.m.				having the potential to be		
					affected by the same deficien	nt	
	Diagnoses for I	Resident #5 included,			practice be identified and wh		
	but were not lin	nited to: end-stage			corrective actions will be		
		hypertension, and			taken? Other residents having	Ì	
	diabetes mellitu	• •			the propensity to be affected b		
	นเลมอเซอ เมษิแแ				the alleged deficient practice		
	-	1.7040			would be identified as those		
		ad a signed 7/2/12,			residents receiving hemodialys	sis.	
	physician's ord	er for a daily 1200 ml			None were so identified. Wha		
	(milliliter)fluid re	estriction. The order			measures will be put into pla		
	was clarified 7/	2/12 to be 1500 ml,			or what systemic changes w	ill_	
	and initiated or	,			be made to ensure that the		
		· · · · · · · · · · · · · · · · · · ·			deficient practice does not		
	The recident by	ad a core plan for "At			<u>recur?</u> Nursing staff members		
		ad a care plan for "At			have received training related	το	
		ectrolyte imbalances			the completion of the intake		
	_	renal failure" with			sheets for residents on hemodialysis. Licensed nursir	na	
	interventions of	f:			staff has received training rela	•	
					Start has received training fela	i c u	

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Event ID: 5ZUI11

Facility ID: 000556

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURV	EY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		155747	B. WIN			08/24/2012	2
		1	B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ERCER AVE		
WOODC	REST NURSING C	ENTER			UR, IN 46733		
				DLOAT			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	MPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	·	<u> </u>	DATE
					to the necessity of fistula		
	a. Fluid restric	ction of 1500 ml daily			assessment q shift. How will the corrective actions be	"	
	b. Measure/record intake and output				monitored to ensure the		
					deficient practice does not		
	every shift				recur?		
					Unit manager will audit the		
	c. Assess fistu	ıla everv shift			documentation Monday to Friday, to		
		- y			ensure that the resident's care plan mentioned is being followed. A	as	
	Review of the	July intake and output			summary of these findings will be		
		ed on the following			forwarded to the DNS or designee to)	
		•			present to PI/QA&A Committee for review, monthly for 3 months and		
	dates and times Resident #5 did not have intake monitored as ordered:				quarterly thereafter. Recommendation		
	nave intake mo	onitored as ordered:			for changes to the monitoring sched		
					will be forwarded back to the Directon Nursing for implementation.	r ot	
		ake recorded for the			By what date will the system	nic	
	3:00 p.m11:0	0 p.m. shift, or daily			changes be completed?		
	total				September 15, 2012.		
	7/7/12 - no inta	ake recorded for the					
	3:00 p.m11:0	0 p.m. shift, or daily					
	total						
	7/10/12 - no in	take recorded for the					
	3:00 p.m11:0	0 p.m. shift, or daily					
	total	, , , , , , , , , , , , , , , , , , ,					
		take recorded for the					
	_	0 p.m. shift, or daily					
	total	o p.m. simt, or daily					
		take recorded for the					
		00 a.m. shift, or daily					
	total						
		take recorded for the					
	· ·	0 p.m. shift, or daily					
	total						
	7/17/12 - no intake recorded for the						
	3:00 p.m11:0	0 p.m. shift, or daily					
	total	•					
		take recorded for the					

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Event ID: 5ZUI11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155747	B. WIN	G		08/24/	2012
NAME OF P	ROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TORNING OF T	NO VIDEN ON SOITEEL				ERCER AVE		
WOODC	REST NURSING C	ENTER		DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	00 a.m. shift, or daily					
	total						
		n the resident not being					
		he physician ordered					
	_	iction for 8 of the 29					
	days reviewed in July 2012.						
	David 511	Lists as one of					
		July nurses notes					
		e following dates and					
	times Resident #5 had his fistula						
	assessed:						
	7/2/42 at 2:00						
	7/3/12 at 2:00	•					
	7/8/12 at 8:00						
	7/10/12 at 12:0	•					
	7/24/12 at 6:00	a.m.					
	This regulted in	n the resident's fistula					
	being assesse						
	opportunities.	u 4 out of 87					
	opporturities.						
	During an inter	view with RN #1 on					
	_	a.m., she indicated					
		ort the fluid intake for					
	-	e nurse and the nurse					
		ts the intake on the					
		tput record. She also					
		esident's dialysis					
		sessed after dialysis on					
		is treatment form, and					
	•	dication Administration					
	Record (MAR)						
	During on inter	wiew with the Director					
	uning an inter	view with the Director					

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Event ID: 5ZUI11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155747		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COM	te survey ipleted 24/2012	
	PROVIDER OR SUPPLIEF		STREET A	ADDRESS, CITY, STATE, ZIP C ERCER AVE UR, IN 46733	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
TAG	of Nursing on 8 additional information related to the more restriction and dialysis fistular. The facility fails additional information 8/24/12. 2.) Review of the policy, dated 1 "DIALYSIS/HE the table on 8/2 included, but we following: "II. Purpose: I care of residents: III. Procedure:	mation was requested nonitoring of the fluid assessment of the for Resident #5. ed to provide any mation as of exit on the current facility 0/11, titled MODIALYSIS", left on 24/12 at 8:20 a.m., vas not limited to, the Provide appropriate at receiving Dialysis/ Hemodialysis.	TAG	DEFICIENCY)		DATE

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Event ID: 5ZUI11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURV	EY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED	
		155747	B. WIN			08/24/2012	2
NAME OF D	ROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1300 M	IERCER AVE		
WOODCI	REST NURSING CI	ENTER		DECAT	UR, IN 46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
F0309 SS=D	483.25 PROVIDE CARE	/SERVICES FOR					
00 2	HIGHEST WELL						
	Each resident must receive and the facility						
	•	necessary care and					
		or maintain the highest					
	practicable physic						
		l-being, in accordance with ve assessment and plan of					
	care.	ve assessment and plan of					
	Based on reco	rd review and	F03	09	It is the policy of this provider t	o 09/	/15/2012
	interview, the fa	acility failed to monitor			provide the necessary care an	d	
		bowel obstruction			services to attain or maintain the	ne	
	[Resident #18]	for 1 of 10 residents			highest practicable physical, mental and psychosocial		
	reviewed for ur				well-being, in accordance with	the	
	medications.	,			comprehensive assessment ar		
					care plan. The provider		
	Findings includ	le:			respectfully request IDR of this	1	
	G				alleged deficiency. <u>1. What</u> corrective action will be		
	Resident #18's	clinical record was			accomplished for those resider	nts	
	reviewed on 8/	23/12 at 8:52 a.m. The			found to have been affected by		
	resident's diagi	noses included, but			the deficient practice: Residen		
	were not limited	d to, status post small			#18 did not return to the facility	′,	
	bowel obstructi	ion of the ileus, atrial			no action is required for this resident. 2. How other residen	ute.	
	fibrillation, hype	ertension, congestive			having the potential to be affect		
	• • • • • • • • • • • • • • • • • • • •	nd chronic back pain.			by the same alleged deficient		
	, -	•			practice will be identified and		
	Review of Resi	ident #18's nursing			what corrective action will be		
	notes indicated	•			taken: Other residents with the		
		m., The resident was			propensity to be affected by the		
	•	derate amount of brown			alleged deficient practice were identified as those with nausea		
	-				and vomiting. None were so	'	
	•	6:00 p.m. medications			identified. The unit managers v	vill	
		e resident was given 30			during daily review, will monito		
	-	in antacid.] Her vital			any residents identified with		
	_	ained at the time with			nausea and vomiting or possib	le	
	no abdominal a	assessment.			bowel obstruction. <u>3. What</u>		
					measures will be put into place	e or	

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Event ID: 5ZUI11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED	
		155747	B. WIN			08/24/2012	
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			ERCER AVE		
WOODC	REST NURSING C	ENTED			UR, IN 46733		
		LIVILIX		DLOAI			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	i.
	8/6/12, 8:00 p.	m., The resident			what systemic changes will be	-	
vomited a moderate amount of brown					made to ensure that the allege		
	liquid and her 8:00 p.m. medications				deficient practice does not rec		
	were held. No	vital signs or			The process of reading all nurse notes on a daily basis (in place		
		essment was obtained.			for > one year) by the Unit	,	
		occinione mae obtained.			Managers will continue		
	8/6/12 11:00 -	m "Dr called Boo			unchanged. The unit manager	s	
		o.m., "Dr. called. Res			will during that review, will mor		
	-	gic to Phenergan [for			any residents identified with		
		omiting.] [Circle with a			nausea and vomiting or possib		
	line through it]				bowel obstruction. The weekly		
	[nausea/vomiti	ng] med [medication]			Resident Care Committee will		
	available. Ord	er received to send res			review 3 charts randomly	L	
	to [name of ho	spital] ER [emergency			selected to assess if a patient nausea and vomiting or a	nas	
	room.] Daught				possible bowel obstruction and	Lif	
					affirmed, that physician	' ''	
	8/7/12 3·30 a	m., Received a call			notification has occurred within	ı a	
					professional standard parame		
	1	gency room and the			If it has not, corrective		
		eing admitted with a			in-servicing will occur. A		
	l •	l obstruction and			summary of these findings will	be	
	hypokalemia.				forwarded to the DNS or	_	
					designee to present to PI/QA8		
	8/7/12, late en	try for 8/6/12, 11:00			Committee for review, monthly		
		dent had vomited a			3 months and quarterly therea 4. How the corrective action was		
	l •	of brown liquid. No			be monitored to ensure the	<u> </u>	
	•	the abdomen or vital			deficient practice will not recur	i.e.	
					what quality assurance progra		
	signs were cor	iipieteu.			will be put into place: The		
	The second 11 11				PI/QA&A Committee will review	v	
		ad a 7/23/12, care plan			the summary from above and		
	1 .	ential for discomfort,			make recommendations based		
	complications	related to constipation.			on the summaries for continue		
	An approach for	or the problem included			monitoring. <u>5. Completion dat</u>	<u>e:</u>	
		report to MD as			September 15, 2012.		
	needed signs and symptoms of						
	constipation/fe						
		-					
	abuominai pair	n, abdominal distention,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/25/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUILDING B. WING	COMPLETED 08/24/2012	
	PROVIDER OR SUPPLIER REST NURSING CENTER	1300 M	ADDRESS, CITY, STATE, ZIP CODE ERCER AVE UR, IN 46733	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	straining at stool, hard stool, nausea/vomiting, fever, and altered mental status.			
	During an interview with the Director of Nursing on 8/23/12 at 3:30 p.m., she indicated she had no further information to provide related to the abdominal assessments and the physician not being notified until 8/6/12 at 11:00 p.m. 3.1-37(a)			

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Event ID: 5ZUI11

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155747	B. WIN			08/24/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ERCER AVE		
WOODCI	REST NURSING CI	ENTER			UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0431 SS=B	483.60(b), (d), (e) DRUG RECORD & BIOLOGICALS The facility must of services of a licer establishes a system and disposition of sufficient detail to reconciliation; and records are in ordinal controlled drug periodically recondically recondicated the approximation of the facility must is biologicals in lock proper temperature authorized personal keys. The facility must permanently affix storage of control Schedule II of the Abuse Prevention and other drugs is when the facility is drug distribution is	employ or obtain the nsed pharmacist who tem of records of receipt fall controlled drugs in enable an accurate d determines that drug der and that an account of gs is maintained and inciled. icals used in the facility in accordance with currently innal principles, and priate accessory and etions, and the expiration able. Ith State and Federal laws, tore all drugs and ed compartments under recontrols, and permit only innel to have access to the provide separately locked, ed compartments for elled drugs listed in a Comprehensive Drug in and Control Act of 1976 subject to abuse, except uses single unit package systems in which the		IAG	DEPICIENCY)		DATE
	dose can be read Based on obse the facility faile and bottles of t	minimal and a missing lily detected. ervation and interview, d to ensure the tubes opical medications abeled with resident	F04	31	It is the policy of this provider to ensure tubes and bottles of topical medications are proper stored and labeled. What corrective actions will be		09/15/2012

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Event ID: 5ZUI11

Facility ID: 000556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X2)		X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED	
		155747	B. WIN			08/24/2012	2
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
MOODO		ENTED			ERCER AVE		
WOODC	REST NURSING C	ENTER		DECAT	UR, IN 46733		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COM	MPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1	DATE
	names and ph	ysician's name for 3 of			accomplished for those		
	5 treatment ca	rts reviewed, potentially			residents found to have been	<u>1</u>	
	affecting 89 residents living on Peach,				affected by the deficient		
	Spring and Maple Street Halls of 126				practice? The improperly labe		
					tubes/bottles of topical medica	tion	
	residents in the facility. Findings include:				were disposed of and replacements were		
					received. How will other		
					residents having the potential	,,	
					to be affected by the same	<u> </u>	
	1. On 8/23/12	at 1:40 p.m., while			deficient practice be identifie	ed	
	observing med	lication storage, tubes			and what corrective action w		
	of medicated ointments, creams and				be taken? Other residents wi		
	dry powder were found without labels				the propensity to be affected b		
	to identify which				the same alleged deficient		
	1				practice would be identified as		
		onged on treatment			those residents that have		
		e, Peach and Spring			unlabeled topical medications.		
	Street Halls.				None were so identified. Wha		
					measures will be put into pla		
	The treatment	cart for Peach Tree			or what systemic changes w	<u>'''</u>	
	Hall contained	the following tubes of			be made to ensure that the deficient practice does not		
	ointments and	creams without			<u>recur?</u> Nursing staff members	2	
	resident specif				have received in-servicing rela		
		etamethasone(topical			to maintaining the boxes which		
		· •			the labels are usually attached		
	antifungal) and	•			Nurse managers will audit the		
	100,000(topica	ai antifungai).			carts to ensure that medication	ns	
					are labeled appropriately. A		
	The treatment	cart for Spring Street			summary of these findings will	be	
	Hall contained	the following tubes of			forwarded to the DNS or	,	
	topical medica	ted creams and lotions:			designee to present to PI/QA8		
	-	e 2.5%(topical steroid)			Committee for review, monthly 3 months and quarterly	101	
	1 -	2%(topical antibiotic).			thereafter. <u>How will the</u>		
					corrective actions be		
	The treatment	part for Mania Street			monitored to ensure that		
		cart for Maple Street			deficient practice will not		
		the following bottle of			recur?Information gathered from	om	
	topical medica	•			the audits will be forwarded to		
	Nystop(topical antifungal).				PI/QA&A committee monthly f	or	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUILDING B. WING	COMPLE 3 08/24/2	ETED		
	ROVIDER OR SUPPLIER REST NURSING CENTER	1300 MERCER AV	STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CO CROSS-REI	VIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
	Interview on 8/24/12 at 9:55 a.m. with DON indicated the Pharmacy Consultant reviews and checks the medication and treatment carts monthly and were last checked on 7/19/12. 3.1-25(j) 3.1-25(k)	inclusion recomme monitorin systemic	, review and endation for further ing. What date will the changes be ed? September 15,			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE :	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155747	B. WIN			08/24/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ERCER AVE		
WOODC	REST NURSING CI	ENTED			UR, IN 46733		
WOODCI	REST NURSING CI	ENTER		DECAT	UK, IN 40733		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES						
		PLETE/ACCURATE/ACCE					
	SSIBLE						
	-	maintain clinical records on					
		accordance with accepted					
	· ·	dards and practices that					
		curately documented;					
	_	e; and systematically					
	organized.						
	The clinical recor	d must contain sufficient					
	The clinical record must contain sufficient information to identify the resident; a record						
		assessments; the plan of					
		s provided; the results of					
		screening conducted by					
	the State; and pro						
	Based on reco	rd review and	F05	14	It is the policy of this provider t	0	09/15/2012
		acility failed to ensure			ensure that the resident clinica		
	resident clinica	•			records are complete and		
					accurately documented. Wha	<u>t</u>	
	•	accurately documented			corrective actions will be		
		dents reviewed for			accomplished for those		
	•	accurate clinical			residents found to have been	<u>1</u>	
	records. (Resi	dent #5)			affected by the deficient		
					practice? Resident #5 will have		
	Findings includ	e:			the fistula assessed each shift	•	
	3 - 1 - 1				and the fluid restriction of 1500		
	1) The clinical	I record for Resident			maintained by record of intake How will other residents		
	,	ed on 8/23/12 at 8:20			having the potential to be		
		50 011 0/23/12 dt 0.20			affected by the same deficier	nt	
	a.m.				practice be identified and wh		
					corrective actions will be	<u> </u>	
	Diagnoses for	Resident #5 included,			taken? Other residents having		
	but were not lin	nited to: end-stage			the propensity to be affected b		
	renal disease.	hypertension, and			the alleged deficient practice	-	
	diabetes melliti	•			would be identified as those		
					residents receiving hemodialys		
	The recident by	nd a signed 7/0/40			None were so identified. Wha	_	
		ad a signed 7/2/12,			measures will be put into pla		
	∣ physician's ord	er for a daily 1200 ml			or what systemic changes w	ill_	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155747	B. WIN			08/24/2012	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF I	PROVIDER OR SUPPLIEF	₹			ERCER AVE		
WOODC	REST NURSING C	ENTER			UR, IN 46733		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		1
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	, ,	restriction. The order			be made to ensure that the		
	was clarified 7/2/12 to be 1500 ml,				deficient practice does not		
	and initiated on 7/3/12.				<u>recur?</u> Nursing staff members have received training related		
					the completion of the intake	10	
	Review of the	July intake and output			sheets for residents on		
	record indicated on the following dates and times Resident #5 did not				hemodialysis. Licensed nursi		
					staff has received training rela	ted	
		onitored as ordered:			to the necessity of fistula		
					assessment q shift. How will	<u>the</u>	
	7/4/12 - no inta	ake recorded for the			corrective actions be monitored to ensure the		
	3:00 p.m11:00 p.m. shift, or daily total 7/7/12 - no intake recorded for the				deficient practice does not		
					recur?		
					Unit manager will audit the		
					documentation Monday to Friday, to		
	I -	0 p.m. shift, or daily			ensure that the resident's care plan (fistula assessment and fluid intake)	as	
	total				mentioned is being followed. A		
		take recorded for the			summary of these findings will be		
	I -	0 p.m. shift, or daily			forwarded to the DNS or designee to present to PI/QA&A Committee for		
	total				review, monthly for 3 months and		
	7/12/12 - no in	take recorded for the			quarterly thereafter. Recommendation from the PI/QA&A committee for	ons	
	3:00 p.m11:0	0 p.m. shift, or daily			changes to monitoring schedule will	be	
	total				forwarded back to the Director of		
	7/13/12 - no in	take recorded for the			Nursing for implementation.		
	11:00 p.m7:0	00 a.m. shift, or daily			By what date will the system changes be completed?	mic.	
	total	•			September 15, 2012		
		take recorded for the			23513111331 13, 2012		
		0 p.m. shift, or daily					
	total	o p.i.i. orint, or daily					
		take recorded for the					
		0 p.m. shift, or daily					
	total	taka maaandad fa a tha a					
	7/30/12 - no intake recorded for the 11:00 p.m7:00 a.m. shift, or daily						
	total						
	This resulted in	n the resident not being					
		i inc resident not being					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		155747	B. WIN			08/24/2	2012
C OF P			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	· ·		1300 M	ERCER AVE		
WOODCI	REST NURSING C	ENTER		DECAT	UR, IN 46733		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		he physician ordered					
	1	iction for 8 of the 29					
	days reviewed	in July 2012.					
	The resident h	ad a care plan for "at					
	risk for fluid/electrolyte imbalances due to dialysis/renal failure" with interventions of: Assess fistula every shift.						
	Review of the	July nurses notes					
	indicated on the following dates and times Resident #5 had his fistula						
		t #3 Had His Hstala					
	assessed:						
	7/2/12 at 2:00	n m					
	7/3/12 at 2:00	•					
	7/8/12 at 8:00	•					
	7/10/12 at 12:0	•					
	7/24/12 at 6:00) a.m.					
	This resulted in	n the resident's fistula					
	being assesse						
	1	a + out of or					
	opportunities.						
	During on inter	ariour with DNI 44 as					
		view with RN #1 on					
		7 a.m., she indicated					
		ort the fluid intake for					
		e nurse and the nurse					
		ts the intake on the					
	Intake and Out	tput record. She also					
	indicated the re	esident's dialysis					
	access was as	sessed after dialysis on					
		is treatment form, and					
	1 .	dication Administration					
	Record (MAR)						
		•					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155747		A. BUILDING B. WING		COMPLETED 08/24/2012	
NAME OF PROVIDER OR SUPPLIER WOODCREST NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1300 MERCER AVE DECATUR, IN 46733		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	of Nursing on 8/2 additional informa	ation was requested nitoring of the fluid sessment of the Resident #5.			

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